Session No. 613

Culture is Quantifiable

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Background/Basics

"The proof of the pudding is in the eating." We've all heard this proverb and remember it because it is simple, evokes emotion, and clearly and concisely delivers a message through a very short story.

We all know from experience that culture is the operating system for safety programs. If the culture is bad, the success of programs is seriously jeopardized. And, if you don't know where you are culturally and/or where you want to go to, the chance of arriving at a loss resistant environment is very low. So, it is essential to be able to quantify culture. "If you can't measure, you can't manage." And, "What gets measured gets done."

A lot has been said about culture and everyone is saying that what they do will improve culture. Most of them are at least partly right. Everything we do affects culture and if we are experienced and smart, we will make more good decisions than bad. But, without measurement, we'll never *really* know just how smart we have been. Nor, will we be able to demonstrate to others the positive results of what we have done.

Getting Through the FOG – The Measurement Farce

So much has happened over the years to corrupt the practice of loss prevention. Current methods of measurement of safety performance are very near the top of the list. We basically have three ways we currently measure safety. We use workers' compensation costs, audit results, and accident rates. They are all retrospective, and can be manipulated with such ease that it would seriously bore Andrew Fastow, the former *Enron* CFO, who is doing his manipulation behind bars now.

Let's take a brief look at each of these systems to give us some perspective on why we need to turn to culture quantification…FAST.

Workers' compensation costs are based on three years experience that begins as far back as four years ago. Often they have as much to do with how claims are handled as with how the accident prevention effort is doing. Such things as the nature and quality of nursing and medical services are other significant factors. And, those costs only represent the "tip of the iceberg."

The subject of the cost of losses is best treated in the *Benchmark Survey* produced by *Ernst & Young*.

The goal and objective of every CEO is the same: They are charged with providing stockholders with the best return on their investment (ROI) that is possible in the business in which they are engaged. The best single way to achieve that objective is to avoid unnecessary losses and in so doing minimize the cost of risk (COR) of the organization. This fact is rarely recognized and even less frequently discussed in any detail.

The COR is comprised of net insurance premiums, retained losses, risk control, and loss prevention expenses and administrative costs. There are three exposures that are considered: property, tort liability, and occupational disease or injury. There are six types of costs within these three exposures: insurance premiums; retained losses; internal administration; outside services; financial guarantees; and fees, taxes, and other similar expenses.

The *Ernst & Young Benchmark Survey* suggests that loss prevention should be the number one priority of almost every CEO. Yet it is clearly not: Why is that?

There is not just one reason just as there is almost never one reason for any accident or dysfunction. Here are the main reasons that this important fact has been overlooked:

- It has been deliberately – and very effectively -- masked by special interests in the insurance industry.
- Very few CEOs have even a working knowledge of the rudimentary aspects of insurance and loss prevention…and, they have been discouraged from changing that situation.
- The depiction of costs and their impact on profitability have been crude and rarely synthesized in a cohesive and comprehensive fashion.
- The "big lie" that these costs of risk are essentially a cost of doing business and are not very controllable has been accepted.
- The concept that culture cannot be directly correlated with performance and even if it could, it can't be measured is generally accepted: It is wrong!

The *Benchmark Survey* reveals the "tip of the iceberg" but does it in such a fashion that the proper response is rarely elicited. The COR is described in terms of dollars per thousand dollars of revenue. Since the COR goes directly to the bottom line, it would be more appropriate to describe it in relationship to profits. The accumulated costs are based on what an insurance department can easily capture, not what is in fact the real cost. For example: The time spent by employees on safety meetings, job observations, and safety education and training are never captured; The resources expended for outside services such as consultants and contractors who incur and pass on safety costs are not captured; The retained losses only include those losses captured on claims status reports and have no way of accounting for costs associated with minor incidents paid for locally. Property damage that goes into maintenance budgets is never accounted for. It is not unreasonable to assume (and justify) that the real COR is much larger than the *Benchmark Survey* suggests and may even be several times the numbers reported.

Never the less, even the numbers reported are eye openers when placed in the proper context. The cost of risk ranges from a low of $0.27/$1,000 for banking and finance to a high of $27.45/$1,000 for transportation and shipbuilding. The average for all industry is $5.25/$1,000.

So, at the end of the day, nobody is listening, the information is seriously incomplete, it is tainted by factors not even considered, and it is so old that in a world that finds trouble thinking beyond the day, much less the end of the quarter or three to four years ago, it has almost no value from a measurement standpoint.

With regard to audits, they are probably the best of the three bad systems of measurement we use. But, their nature and quality vary so widely because the auditors are rarely properly qualified -- not to mention the fact that most of what is usually being audited clearly falls into the symptom rather than cause category. Inconsistencies dominate the processes and the whole thing lends itself to knee jerk reactions that often add more confusion than clarification. Having said all that, a good audit program, done with consistency and professionalism, by well-trained auditors, can be very valuable, particularly if information on culture is part of the audit.

As to accident rates, they are less than useless in many cases. In his article, "Caution Beware of OSHA Statistics" published in *Professional Safety*, Dan Zahlis does a masterful job of explaining how OSHA incidence rates are at times inversely related to true accident prevention performance largely because it results in underreporting and masking root causes. In a more recent *PS* article -- "Beware the Disconnect" -- Dan and Larry Hansen elaborate on why injury statistics are more a part of the problem than a part of the solution. I would encourage all serious safety professionals to read both of these articles carefully. The details of why accident statistics just confuse us are beyond the scope of this paper but well covered in the work of Zahlis and Hansen.

Now I need to talk about those who claim that their program or process has produced documented improvement in safety records. Even if our methods of measurement were valid, these claims for ANY program or process cannot be supported by REAL facts. The reason is because the only way you could do that was to hold EVERYTHING constant during the period of evaluation EXCEPT the changes made with the new BBS program or other initiative. That can't be done, so any improvement – or for that matter regression – cannot be attributed to any single initiative and anyone who claims to be able to do so is at least wrong and probably could fit the description of a "blowhard." ALL this kind of information is anecdotal and should be dismissed by any serious person.

Real-life experiences

Now for what really counts. Safety culture measurement has been applied by hundreds of people around the world. None have reported that is was not worth the effort. Some have gotten more from the process than others. Below are the observations and reflections of three people who have pretty extensive experience with safety culture evaluation. We can all learn something from each of them. This IS where "the rubber meets the road."

Rick Hill, CSP, CPEA, REM, has significant business background with large and sophisticated companies. Here is what he has to say:

"The Edge of Spectacular Failure" After many years as a Safety Professional, I've come to realize that each day there is the potential for the spectacular results an organization has

accomplished in safety to turn on a dime. I believe this is because people are a key ingredient to a safe work environment, and unfortunately nowhere in life are people a reliable constant.

Several years ago I encountered a very dynamic speaker named Ed Foreman who taught about "Successful Living". Ed believed, and I agree, that individual success is a direct result of one's character. Ed taught that thoughts become actions or behaviors, the same behaviors over time form habits, and habits result in character. He believed that successful people make a habit of doing the things that unsuccessful people don't like to do.

The truth has a ring to it, and Ed's message rang true in my heart on a personal level. However, I never considered that this philosophy could be used to promote a safe work environment until I met Don Eckenfelder.

I met Don, and first heard of his Values-Driven Safety approach when I was desperately seeking an alternative to Behavior-Based Safety. My management team at the time was convinced that our site must implement BBS to move our safety program to the next level. Although I agreed with them that behaviors were an overwhelming factor that we needed to address, I didn't believe the BBS approach was the right method for us to affect positive behavioral change. They gave me a month to find another method that I believed would work.

As I listened to Don's presentation for the first time, I felt as though I had reached the next step in my personal journey towards understanding this thing we all call Safety. I quickly made the connection between Ed's message of personal character and Don's message of organizational culture. They were virtually the same.

I returned to my management team full of excitement and ideas of how we should proceed. I explained my belief that we could only change behavior in the long term by addressing the values, beliefs, and attitudes of our employees. Although they agreed to use the approach, they chose to use it from a distance while the Safety Department drove the effort. Needless to say, this was mistake number one.

LESSON #1: Site Leadership must completely understand the philosophy, and buy into it 100 percent to have any chance of success. This means they must actively participate in every aspect of the process and lead by example. Also, it is important to educate and involve as many informal site leaders (hourly employees) as possible. These folks have tremendous ability to make or break a site's culture.

I was able to collect data using the standard Culture Barometer and found the results very disturbing. There were tremendous undercurrents of mistrust, feelings of "Safety for the wrong reasons", and an overwhelming sense that employees did not feel personally responsible for their own safety. I immediately scheduled a meeting with my Management Team to share the results and my concerns. As I presented the results, the management team systematically dismissed each clue to our site's culture by rationalizing some other "logical reason" for the feedback we had received. Mistake number two!

LESSON #2: If you ask the question, you must be willing to accept the answer and do something about it. Rationalizing that "they just don't understand the big picture" is the kiss of death. Understand that your employee's perception is their reality, and the truth doesn't really matter

much at this stage of the game. The feedback you receive on the Culture Barometer is your employee's truth, regardless of what the facts are.

I quickly came to realize that our site leadership wanted the employees to change their culture, but they were unwilling to change their own. They were not willing to walk the talk. Through all of my attempts to help them understand, they just didn't get it.

Interestingly, about 2 months later labor relations problems surfaced. A team of corporate experts came to town to determine the issues. They found, for the most part, what the Culture Barometer had already told us. From that point on, the culture began a downward spiral that continues to have effects today…as I am told.

LESSON #3: Culture does predict performance. When the labor relations issues began, virtually every aspect of the operation suffered. (Safety, Quality, Production, Financial Performance)

Fortunately, I was able to advance my career by obtaining my current position with *Weyerhaeuser* before most of the turmoil unfolded.

I have since implemented the VDS philosophy at my current facility with a leadership team that is sold on the idea. My Plant Manager is the biggest fan of the approach and leads the team daily by his example. He holds the rest of the site leaders accountable to do the same.

We've involved 40 informal site leaders (10% of the Plant Population) in the process, by educating them about the approach and engaging them in the process. The management team worked with this group to customize the culture barometer so that it reflects our site values and desired culture. Hourly participants were hand picked by the management team based on their perceived ability to positively influence co-workers.

The team of 40 assisted the management group in analyzing the results of the Culture Barometer. The Management Team accepted the results as truth and developed an action plan to address each major finding.

In the 8-month process we reduced RIR from 3.5 to 1.5 with record periods of time between recordable incidents. Workers' Compensation costs dropped from approximately 50K in 2005 to 5K in 2006 providing clear evidence that injuries were dramatically less severe. Of course, I can't say that these improvements were only because of Values-Driven Safety. There were nearly 400 people who individually made a focused effort, and many other factors that lead to these results. However, I do believe the "new mindset" played a key role.

CONCLUSION: As our site began 2007, the wheels came off our Safety effort with our first Culture Barometer action plan only 80% completed. In the period of time between January 30th and February 10th 2007 our site experienced 4 recordable injuries, two less than the entire previous year. Why?

LESSON #4: Culture can turn on a dime. What is valid information today may not be reliable 3 months from now. Subtle changes can have more of an impact that one might think. In our industry, market conditions had resulted in some facility closures and layoffs at other plants. Our own plant had experienced production curtailments, reduced work schedules, and shift

rearrangements. We had evolved into a new culture within a few short months without realizing it. On the morning of January 30th without knowing it, we were on the verge of spectacular failure.

Our management team has now regrouped and refocused our safety effort with a new understanding of the fragile nature of culture. We are now more sensitive to the subtle clues that something may be changing and we have regained confidence that we can control our own safety destiny.

Steve Arblaster, CSP is a well-respected safety professional working for a high-tech division of one of the most admired companies in the world…*GE*. He has this to say about some of his experiences with safety culture measurement and management:

Introduction: *GE Transportation* manufactures and sells passenger and freight locomotives for its railroad customers around the globe. Full service contracts are subsequently sold where a *GE* management team will supervise railroad workers at rail yards engaged in servicing and repair these locomotives. Since each railroad is its own company, there are unique safety cultures that *GE* must operate in while executing the service contracts. *GE* supervises railroad maintenance craft workers at these locations. Typically, as with this case, the workforce is divided between *GE* supervised teams, and railroad supervised hourly teams. Our intent of this process was to measure the safety culture on each "side" of the shop and compare the data and look for how to improve both "sides".

The Training Process: Don Eckenfelder and I visited the site and trained site management teams on the theory, concepts, and measurement process during a several hour training session.

Data Collection: After the training session, we set out to the daily shift change turnover meetings to collect the site's safety culture data using the standard safety culture barometer form. We started each meeting with a 5-minute overview of the process, and a request of the hourly teams to help us in the process by giving us their opinion on how they would rank their day-to-day experiences in each of the 10 safety values, using a scale of 0 to 5. We received a very high participation rate across all shifts.

Data Tabulation: The raw data from the data collection forms were entered into the Safety Culture Profiler software for tabulation.

How Do We Get Better? As with many things in life, there are no shortcuts. Sustainable improvements result from hard work, and this process is not exception. In order to get better, we had to develop exercises that the management team would initiate, but that all employees would participate in and benefit from.

Corrective Action Planning: Don provided generic recommendations and suggestions for practical exercises. The site team took its knowledge of their industry and site processes and customized the exercises to develop a plan to improve on each element, but with special emphasis on the values ranked the lowest by the employees.

The site team and the business EHS team developed a customize action plan based on Don's generic recommendations, but significantly expanding by inserting specific actions that fit only

those working in this industry, market, and for this particular customer. This is the most challenging part of the process, and not for the weak at heart. The culture barometer and data collection process is an introspective look at your safety culture. Once you receive the data and take that look, the question quickly becomes, "What are we going to do about it?" The "we" part of that last sentence is the key. Don't look for Don or any other consultant to come in and solve your safety problems. If you are looking for that, you just another EHS professional engaged in your eternal search for the silver bullet. That is not what this process is about. It is about making you and your employees aware that you have a safety culture, and that it can be defined, measured, and improved upon using this process, similar to any other process that involves data. For those of you that are familiar with Six Sigma, is any of this starting to sound familiar? This process will lay out what the concept of a safety culture is, and how it can be measured. The improve phase, (both the plan and the execution of the plan) must come from within the teams who will execute the plan.

Posting the Results: A key part of any effective corrective action plan is communicating the data collection results back to the employees. We decided to do this by posting the summary charts with brief explanations and the corrective action plan on dedicated bulletin boards throughout the facility. This provided the highest level of transparency, which helped maintain the credibility of the process with the employees.

Executing the Plan: Each member of the management team, from the shop leader had action items to complete in the corrective action plan. In our particular case, we used an online action item tracking system that send out automatic reminders at a pre-determined frequency as due dates approached. However one decides to track it, the important thing is to track it, and ensure you execute on the activities, plans, improvements, fixes, or any other item(s) that consist of your safety culture improvement action plan. Credibility rides on this execution.

Site Specific Results: The site's safety performance improved dramatically over the next several years, including experiencing very long periods (over 1 year) of injury free performance. These sites periodically (two or three times per year) re-score the culture barometer, and continually renew and improve their action plan with the emphasis being on continuous improvement. The subsequent rescoring at this site has shown a steady increase in the safety culture scores, resulting in a strong correlation between the increase safety culture scores and the site's safety performance.

Summary: In summary, the product is the process, and the process is designed to quantify your site's safety culture. Once measured, any process can be improved, and with the right energy and commitment, can result in a significant safety performance improvement. Using Sigma Terminology, this process will get you through the Define, Measure, and Analyze phases. The Improve / Control phase comes from a the site team looking inward and subsequently reaching outward to the employees in the form of a corrective action plan that the management team executes in the form of targeted exercises that will improve a site's safety culture and result in improved safety performance.

Mark Jentsch was the safety director for the city of Launceston, Tasmania, Australia when he attended one of our seminars at the Antarctic Expedition Center outside Hobart, Tasmania. He purchased a *Values-Driven Safety Applications Manual* and went about Australianizing our

methodology. Later, he reported some results to me as he worked in another position on the Gold Coast of Australia but keeping in touch with some of his old colleagues in Launceston.

Here is what Mark had to say:

Sowing the seeds between the 'Rock and the Hard Place'. Launceston City Council's civil works division (Total Workforce) displayed many of the relationship hallmarks expected in a traditional blue-collar work environment. Mistrust between management and the work force was the order of the day, with a resultant detrimental impact on the effectiveness of operations.

What were the indicators of this relationship and how were they to be utilized to improve organizational performance?

It is commonly held that one's belief is reality. What you truly believe to be true will drive your views and personal philosophies until incontrovertible evidence is put forward to alter your beliefs.

Middle management within Total Workforce held the belief that:

- Employees were responsible for their own injuries.
- Employees systematically contravene procedures.
- Employees routinely subverted management efforts at systems improvements.

Employees held the belief that:

- Management was out of touch with shop floor requirements.
- Safety was driven by cost and avoidance of prosecution.
- Management was only interested in enforcing safety when the safety manager was making noise.

The indicators of the quality of this relationship were:

- Poor incident reporting
- Ineffective incident analysis
- Low levels of compliance
- Absence of employee initiatives

After a lengthy period of assessment Behavior-Based initiatives (Krause, McSweeney, Geller) were rejected as it was felt that the workforce would become disenfranchised and the divide between management and workforce would increase.

Larry Hansen and Don Eckenfelder, at the *2004 Safety In Action Conference* held in Melbourne Australia, first introduced the concept of 'cultural enhancement' to key members of the Horticultural Services unit after attending presentations.

Many philosophical discussions took place between Management and supervisors of Horticultural Services and the OHS Officer over the next few months with no clear resolution.

Don then delivered a day seminar on the topic of Values-Driven Safety at the Antarctic Division in Hobart, Tasmania. The Manager Horticultural Services, Team Leader and OHS Officer attended this presentation.

The concept of Values-Driven Safety was well received, but the presentation did not strike a chord with the Australian audience. Further discussions with Manager Total Workforce identified the need to develop relationships with the workplace community. The term ‘workplace community’ formed the foundation for future development of VDS.

Manager Total Workforce took an intuitive leap of faith and approved the purchase and development of VDS within the Horticultural Services Unit.

Key individuals within the crews usually voiced issues within the relationships between management and the shop floor. These individuals were identified as the leaders of an employee subculture. This subculture is the way things really happen at the coalface as against the official viewpoint.

These leaders, within Horticultural Services, were directed to attend a two-day presentation with their managers and supervisors. An additional person was invited to attend from an unrelated area to act as an independent observer.

Attendance was mandatory for the two days, though further involvement was optional. A key viewpoint held by attendees was that this was ‘another bloody safety program’. This indicated a level of frustration within the workforce with ineffective safety initiatives.

Don’s introductory presentation was followed very closely. Day one had a high level of confusion and frustration.

Comments included:

- Who cares what we think? You’ve never asked before.
- Aren’t we eroding management’s power to act?
- Why are we reinventing the system?

Day two introduced a significant change in thinking. Perversely, Don’s PowerPoint presentation united the two disparate groups on a key point. They found the presentation far to ‘American’. They had identified a cultural clash. This opened the door for a team approach to tailoring a safety barometer to meet their understanding and unique culture

After two years the members of the original group still meet on a fortnightly basis. They operate under a loose set of rules.

1. Industrial relations and Human Resource issues are not up for discussion.
2. Personal attacks are not acceptable.
3. All members will take the role of facilitating for extended periods of time.

Two years on, the organization has had significant restructures with changes in Management within Total Workforce and the Horticultural Services team. The Health and Safety role has changed personnel and the role of Launceston City Council has changed three times.

Values-Driven Safety within Horticultural Services is still running strong. Employees have taken responsibility for arranging meetings, venues and minutes upon themselves. The subculture leaders are now in regular communication with management. Management and the leaders work from a united front and identify themselves as leaders of the workplace community.

Horticultural Services is assisting another crew in the establishment of a VDS team. This process has had significant hurdles as management changes occurred as this process was in its infancy. However, they have persevered and improvements in relationships have been felt.

The rock in question was the beliefs management held towards their employees. This belief was their reality.

The hard place was the beliefs of the workforce – their grim reality.

VDS did not change these beliefs, however it did create the opportunity for the two groups to work together, enabling them to challenge and reassess their own beliefs.

Simplistically *VDS* has created a sense of community working towards a common good. It is no longer safety specific, but rather covers a range of processes.

Measurable outcomes of *VDS* to date include a significant improvement in Safety Barometer scores. This is reflected in tangible outcomes including:

- 400% increase in reporting of incidents
- 800% increase in recommendations on systems and safety improvements coming from the shop floor.

Less tangible, though important, is the sense of cooperation and tolerance between supervisors, management and crews.

The future of *VDS* at Launceston City Council is reaching a dynamic phase. The new CEO has requested a presentation from our 'independent observer' on the expansion of *VDS* amongst other divisions. Original team members will in all likelihood drive any expansion.

Wrap-up and Look to the Future

Culture does predict performance and character (in individuals) does predict (individual) performance. Until we act on what we already know, we will continue to experience failures at an unacceptable rate; we will continue to experience "the accident cycle." The quality control mantra, "If you keep doing what you have been doing you will keep getting what you got," is a truism. Those of us who keep doing the same thing and expecting a different result are living the definition of insanity and are – for that time – a little insane.

Until we recognize the criticality of culture and develop universally accepted methodologies to quantify culture, we are doomed to avoid the progress we can and should achieve. I remain confident that some dynamic person who has the ear of the public will champion this cause and lead us to a better place than we now occupy. It is my dream that the safety field can play a leading role in demonstrating the prescience of these processes. We have the knowledge, the "pilot plant", and the positioning. If we don't play a significant role in preventing preventable losses, we have no one to blame but ourselves.

On a personal basis, we plan to learn from our mistakes and improve every day and access the scalability of our intellectual property. The concepts that we have applied to accessing excellence in safety apply equally well to everything from general business, to sports, to education, to health care, and to security and even government. We're planning to "go there." We recognize the need to simplify our message and methods and we're doing that too – every day.

We look forward to others entering this business and bringing new ideas to the table. We think what we have done is relevant, robust, and elegant but we know there is a lot more good information out there and we look forward to stimulating those who have it to share it.

The Basics of a Good Culture Measurement System: Having said all that, there are some fundamental characteristics that we believe should be embodied in any good culture measurement system. They are:

- The premises upon which the culture information is collected must be rooted in well-established social science. Further, it must be based on firmly established attributes, characteristics, or traits of excellence.

- Data must be collected anonymously and needs to be representative of the thinking of the entire group being evaluated.

- The linkage between performance and attributes and beliefs and values must be clear and makes sense to everyone.

- Responses must be quantified, anonymous, and objective.

- The profile must lead to an action plan and then…measurement must monitor success or failure of the exercises prescribed to enrich the culture.

- A culture measurement system must be sensitive to the differences in resident cultures. This means that any process or methodology must be culture sensitive. This cannot be a "one size fits all" process or it will be doomed to failure.

The three people who reported on their experiences with culture quantification in this paper understood and followed these basics. His constituency drove Mark there but I suspect he would have recognized this need on his own.

Summary and Conclusions

"The field is white and ready to harvest." The world has largely recognized the primacy of culture in undesired events. As we examine the *Challenger*, the *Columbia*, *Iraq & WMD*, *Enron*, *Arthur Anderson*, *WorldCom*, *Martha Stewart*, and virtually every other major loss/setback in modern history, we find at the seat of the situation, culture is the root cause. If we deal with symptoms, we will not solve the problems. In fact, we will see them worsen as we doodle away resources on activities that do little or no good and actually provide little more than a distraction.

Culture quantification is not a "magic bullet." You cannot – usually – change culture over night. Without leadership support, this does become – almost – an impossible task. But, having said all that, it is always worth the effort and worth the trip for a wide variety of reasons. But, mostly because, "It is the right thing to do."

The witnesses used in this paper are just a small sampling of the people who have derived benefits from measuring and managing organization culture. There are now hundreds and soon will be thousands and then hopefully millions.

In 2000, the *National Safety Council* empowered a committee to look into the next century and determine what would change in the field of safety and health. One of their top three conclusions was that "culture would become mainstream." We may not be there quite yet but we are not far from it. If you don't jump on soon, you will miss the train and this is a trip you can't afford to miss. As my old friend Chuck Culbertson, the director of safety for *Marriott*, used to have on his stationary: "Can you afford not to do it?"

Recommendations

1. Stop reading safety books and start reading some of the books on this reading list.
2. Set goals for yourself that go beyond implementing current "safety programs."
3. Start thinking "outside the box."
4. Use this culture measurement system, find another one you like better, or devise your own and then sell it to your organization and demonstrate it; then act on the results.
5. Think BIG! You are part of a profession that has most of the answers to all the world's problems. Do something; do anything; do it NOW!

Important Note: Those who attend the paper presentation will have the opportunity to fill-out a safety culture "scoresheet" that will enable them to experience the data collection that produces the safety culture profile. If a paper reader would like the same experience, make an E-mail request to dje@culturethesos.com and we will send you an electronic copy of the *Safety Culture Scoresheet*.

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